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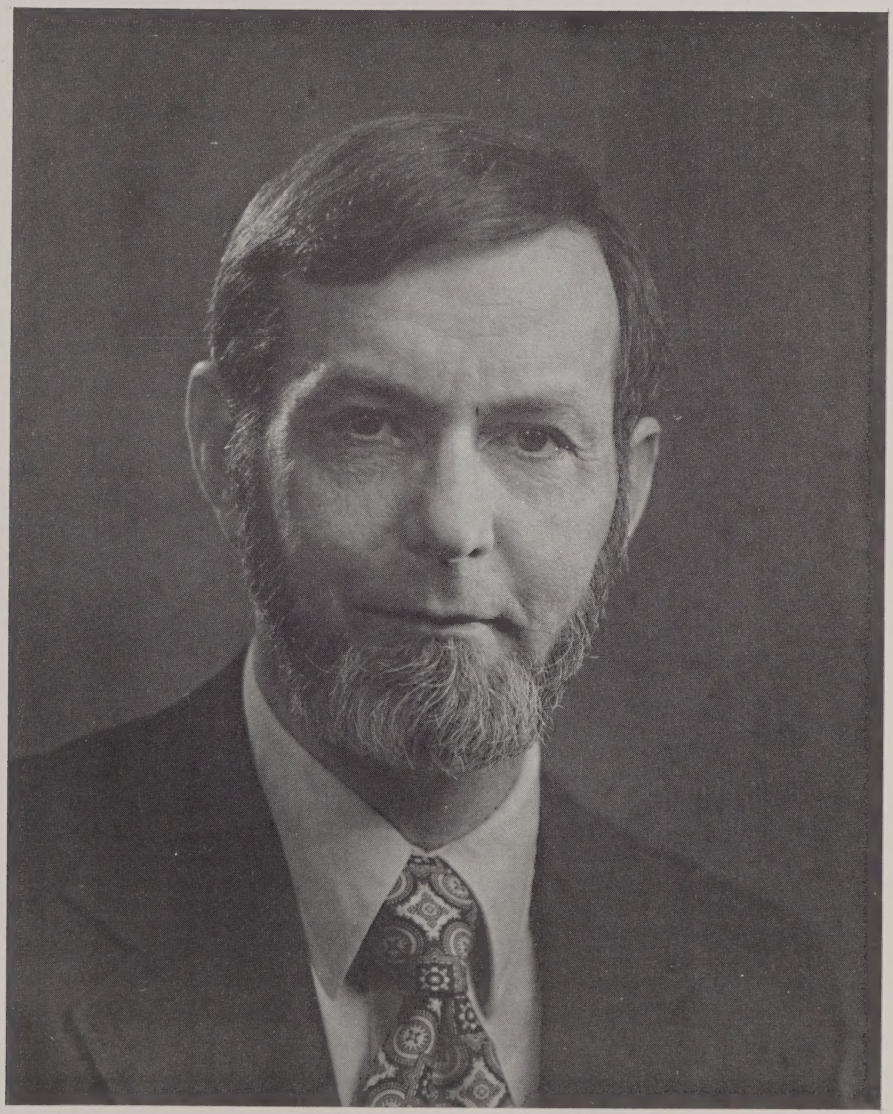
MAY
1976



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Dr. Bruce Stoler's Acceptance Speech:

Members and Guests

of the Hampden District Medical Society:

I accept the honor and the responsibility of being your president during this Bicentennial year.

I will make this address brief and to the point but I want to tell you something about the plans I am making for this society during my term as president. First of all, let me say, I believe the society should not only react to external threats and criticisms, as it has in the past, but it should have a positive program for accomplishment as well.

In those rare moments of solitude which for the physician are becoming ever more rare, I have in the past few months identified seven problem areas confronting our society to which we can profitably address ourselves.

I recognize that there are many more than these seven problems confronting organized medicine today, most of which are national in scope, but to these seven I believe we can develop meaningful local solutions.

My list looks like this:

Problem #1—Traditionally this district medical society, together with the Springfield Academy of Medicine, The John Hunter Society, The Maimonides Society and the local chapters of the specialty societies, formal and informal, have served as meeting grounds for physicians of all hospital staff. But, during the past few years, hospital medical staff duties and loyalties have placed ever-increasing demands upon the staff physician's time, to the detriment of all other organizations. Further, a growing cadre of hospital-employed physicians do not identify with the other practicing doctors of the district and do not make application for membership in our society. At last count there were 171 physicians living in Hampden and eligible for membership who have not applied, and this is wrong!

Problem #2—Those new physicians who do join the District Medical Society do not feel immediately accepted into the fellowship of the society nor represented in its activities, primarily because of an antiquated policy of membership acceptance based on censor review conducted "En Masse" on a semi-annual basis, and this is wrong!

Problem #3—An increasing proportion of foreign medical graduates (now approximately 10%) within our society have not always found free and easy acceptance by the membership or the officers of the society, as indicated by a relatively low representation of foreign medical graduates on committees of the society or among its officers in the past. And more than half of the foreign medical graduates now in our district have not bothered to join at all. And this is wrong!

Problem #4—The media seem to be turning increasingly often to voluntary organizations hospital spokespersons for resource material on health care methods and trends rather than to the doctors own organization, the medical society. I believe this trend can be laid in large part to the difficulty which the media have had in getting any physician-member in private practice to talk to a television, radio, or newspaper reporter. A history of very strict interpretation of ethical prohibitions against solicitation of patients has opened any doctor giving such an interview to charges of unethical conduct by his colleagues, and this is wrong!

Problem #5—There are some doctors among us whose standards are not our standards—perhaps they charge too much, drink too much, practice poor quality medicine, have a drug problem, or you-name-it. In the past the medical society has had little or no effective means to gather such information or to help the offenders, with the net result that nothing has been done until the law is violated and the police step into the picture, to the detriment of all doctors, and this is wrong!

Problem #6—The future existance of a unique and very valuable resource of Hampden district, the Springfield Academy of Medicine, is currently threatened by physician apathy and lack of financial support, and this is wrong!

Problem #7—The society's budget continues to soar skyward, posing the very real threat that continued membership increases may be thwarted, at the very time in the history of organized medicine when the society *must* be able to speak for the majority of the physicians in the district. Some inflation is an unavoidable fact of modern life, but an unrealistic budget and dues structure for the district society if intolerable, and this too is wrong!

During my term as president, I proposed to address these seven urgent problems and, with the approval of the executive committee where necessary, to put into action programs for their solution.

First, I will appoint a *members committee* composed of members of each hospital staff in the district and the board of censors, to serve as a two-way conduit between each hospital staff and the society, to the end that each may be better informed of the activities and policies of the other. I will charge the members of this committee with the task of interviewing, informing about the society and recommending for membership each new member of its medical staff, and this district will begin immediately a policy of bringing new members into the society at any time of year when they have been approved by the censors in accordance with the by-laws. I will ask this committee to make a special effort to recruit hospital-employed physicians as an important leavening influence and a valuable resource of the society. And finally, I will charge the members of this committee with studying and communicating with each member of its hospital staff for the purpose of submitting a specialty listing to the public relations committee for inclusion in the revised yellow pages format of the telephone company.

Second, as one who has had the opportunity to observe and communicate with foreign medical graduates practicing in our midst for a long time now, and recognizing as truth rather than paranoia their feeling that organized medicine has in the past tended to exclude them from influential positions within it, I plan to incorporate them into the committee structure of the society as an important on-going force in medical practice today whose views and opinions need to be heard.

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Third, I will convene an early meeting of your newly elected councilors (who are your delegates to the Massachusetts Medical Society in the ratio of one for each 25 members) to ask each councilor to pick out the 25 member-doctors whose views he will solicit prior to meetings of the council in Boston, and each member of the society will be informed as to whom his councilor is. I will instruct Dr. James Allan, your executive councilor, to be sure that each of the councilors meets with his constituency to discuss those issues which are important, both *before and after* the council meeting, to the end that the councilors may be more aware of the thinking of the members and vice-versa.

Fourth, I will instruct the public relations committee to be especially aggressive in seeking out your individual support in bringing health information to the public through the media. No physician who is designated by the public relations chairman, Dr. Bloom, to speak out on any medical subject of public interest will have to endure the criticism of another doctor on ethical grounds during my presidency. The public, and the officials of our local government should have the benefit of our wisdom in matters of the effect of television violence on our youth, of sulfur content of fuels on our health, on occupational safety, on facilities for the handicapped, and on professional ethics as they affect the public welfare, to name just a few. The Hampden Hippocrat must be more than a "house organ" to communicate with the members, and I will encourage the close cooperation of its board of editors with the public relations and public health committees. I will ask the chairmen of these committees to contribute regular articles to the Hippocrat, speaking out on a variety of subjects on behalf of all the doctors of the district. Since this effort will only be as effective as the proportion of the physicians of this district who are members and for whom we can speak, I will ask the board of editors of the Hippocrat to coordinate with the public relations committee in preparing a booklet outlining the aims of the district society and the benefits of membership therein, for distribution by the members committee to each new physician in the district and to those older physicians who have not yet joined. And I will propose an aggressive campaign to have each member of the district society join the A.M.A. so that our voice may be heard all the way to the national level.

Sixth, recognizing the problems inherent in the threats of the department of justice of the federal government against physicians attempting to determine reasonable fees through the use of relative value guides, the threats of the federal trade commission against ethical restraints to physicians advertising, and the increasing breakdown in the individual doctor-patient relation, manifested in the ease with which the doctor remains detached and unconcerned by viewing his patient conceptually as diseased organs and the resulting ease with which the patient views his doctor's errors conceptually as malpractice, I will request the medico-religious committee to take a new look at the ethical practice of medicine today and to consider drawing up new ethical and moral guidelines for our society for the future. Further, I have requested your new president-elect, Dr. Verrilli, to stay on as chairman of the Peer Review committee with a new responsibility—that of seeking out those doctors of the district who require the special help of the society in solving their personal problems or in changing their modes of practice before the law intervenes.

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Seventh, I am tonight naming Dr. James Fitzpatrick chairman of a blue-ribbon study committee to meet with the board of the Springfield Academy of medicine in order to develop workable solutions to the academy's problems. I do not believe that the society can stand idly by while the academy and its magnificent library and educational efforts founder or are absorbed by one of the hospitals. The facilities of the academy should be available to doctors and other health professionals of this district without restriction as to hospital affiliation, and I plan to do all in my power to see that this is the case. The recommendations of the study committee will be brought to you for your approval before they are implemented.

Finally, always mindful of the constraints of money availability, I will continue the program initiated during this past year of scrutinizing the budget through an oversight "committee on administration" composed of the society's officers and your executive secretary, Mrs. Vivian Purdy (to whom we owe special thanks for administrative support to all of our physicians' efforts) to the end that you can be assured that your dues will be cost-effective.

In conclusion, I wish to thank you again for the honor you have bestowed on me by making me your president. But I can assure you that I do not assume this office for its honor alone, but rather as one who has witnessed over the space of the past seventeen years some wrongs which require to be righted and some misplaced emphasis which need new aim, and welcomes the opportunity to do so. But, let me emphasize this without your support and unified cooperation, I can achieve nothing—with it, we cannot fail.

Bruce B. Stoler, M.D.
President, HDMS

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President's Page

Gentlemen:

I would like to present to you a little different concept of some of my views of the last ten years in the practice of medicine in our district.I would like to ask the question, Is this progress?

In 1965, as you well know, the Federal and State governments started being involved in Health Care on a full time basis with the onset of Medicaire and Medicaid. They said they were getting involved because the elderly and the poor were not able to get care because of cost and availability. It was also felt that care in established clinics and ward services was too impersonal and sometimes of poor quality. The principle was that if you added funds for this care that the Health Care industry would respond and provide it.

The result was somewhat different than was expected as the original premises were wrong. The industry had to expand, the exphasis being on more hospital care and beds, and more services within these settings. Inflation was what should have been expected. However, another cost was added and that was review and audit, both of care and also of financial expenditures and so the per day bed costs have gone out of sight. Doctors have congregated around the hospitals and the result has been less availability, better care for a few and an excess burden of dollars for this care. The planners have purposely killed the cottage industry that was felt to be so inefficient and so unable to be cost controlled.

But what about the patient. Wasn't he the person that this program was started for? He now finds the cost above his means, the availability sometimes at great distances and only after long waits for appointments, and with a doctor that he does not know. And now after being offered a pie in the sky he finds that the state and federal government are refusing to pay and are leaving him with a bill he was not aware of, and not protected against, so he withdraws from the system. He goes to the Emergency Room for care and the lack of continuity and the lack of relationship leave him again stranded with no follow-up and no way to get back to the same M.D. to find out what the hell he had, and what a bill!

While very intensive care for the severely ill has improved, what has happened to the patient with a sore throat is a sin. He is no longer able to afford to take care of it.

And the biggest mistake of all was the interruption and breakdown of the Cottage industry. All the Cottage industry did was make available a local M.D. who the patient could get to know and trust and who had to make his living by getting along with the patient and providing the service at what the patient and he could afford. Inefficient—hardly—for he did care for the patient, did provide the availability and was *responsible* directly to the patient both for the care and the bill.

So, Mr. Legilator, what have you bought with your largesse, your hollow promises, and your ideas that a personalized business could in any way be run like a corporation. Let me tell you again, ... Less availability, less human relationship, bigger and more expensive Health Care Complexes with the same impersonal attitudes that you objected to, and a cost that has no peak as yet, and that is now forcing you to cut back on payments and act like the usual do gooder who offers but can not stand the committment. You have caused the problems, don't blame the Health Care industry. I ask again, is this progress?

Gardner Cox, II, M.D.

Annual Meeting of the HDMS

The Annual Meeting of the HDMS took place April 27 at Chez Josef in Agawam. Committee reports were accepted, President Ford's vaccine program was given a voice support, the Treasurer's report was read and accepted (including a rise in dues to $92.00 per year), and the HDMS Golf Day of August announced.

Dr. George D. LeMaitre, President of the Massachusetts Chapter of the Council of Medical Staffs spoke briefly on that organization's efforts regarding Blue Shield's lock in physicians agreement.

A moment of silence was offered in memoriam for three members deceased, Pasquale Caia, M.D., Howard Jackson, M.D., and Norman Yosko, M.D.

Fifty year certificates were presented to Eugene Beauchamp, M.D., and in absentia Eugene Boss, M.D., and Francis Haggerty, M.D.

New members of the HDMS were presented their certificates.

Dr. Bernard Bloom presented the annual awards to outstanding members of the press media for their contributions to and reporting on medical affairs during 1975. Recipients were Keith Silver, Phyllis Andreoni, and Jane Maroney.

The new slate of officers, censors and councilors was presented by Dr. Howard Ledewitz. The slate was voted upon and accepted as printed.

Gardner Cox, M.D., outgoing president of the HDMS passed the responsibilities of his office to Bruce B. Stoler, M.D., our new President for 1966-77. Dr. Stoler acceptance speech outlined his goals for the society this coming year. Your support and participation will be essential.

Philip B. Stoddard, M.D.
Secretary

Nominating Committee Report

President, Bruce B. Stoler. Vice President and President Elect, Rocco A. Verrilli. Secretary, Philip B. Stoddard. Treasurer, Paul T. Moore. Assistant Secretary, William W. Walthall, Jr. Supervising Censor, Malcom S. Allan (five years from 1972), Censors, (not more than 4 years), John J. Burke, 1972; John J. Flahive, 1972; James H. Mahoney, 1974; Setrag A. Zacarian, 1975; Councilors, James D. Allan, executive councilor; Malcolm S. Allan, Supervising Censor; William Beachman, Bernard Bloom, Public Relations; Eugene G. Boss, Jr., Samuel J. Brendler, Louis A. Corsaro, D. D. Dasco, Ralph E. Gianelly, John F. Griffin, Gary Den. Hough, III, Robert N. LaMarche, Legislative; Richard J. Miller, James H. Mahoney, Agostino Natale, Jack H. Pincus, J. Gordon Rich, Francis J. Riley, Erik A. Rosenthal, Frederick C. Schwendenmann, Nominating; James J. Siragusa, Emanuel Wiedmann, Rocco Verrilli, John C. Ayres, Past President, MMS; Allen S. Johnson, Past President, MMS; Bruce B. Stoler, President, HDMS, Ex-officio, Philip B. Stoddard, Secretary, HDMS, Ex-officio; Paul T. Moore, Chairman Financial Committee—Ex-officio; Lorne C. Smith, Ex-officio; Gardner Cox, II, Tax Supported Medical Care, Louis A. Corsaro; Nominating Councilor, Frederick Schwendenmann; Executive Committee, Eckart Sachsse, John Griffin, Thomas G. Magill; Nominating Committee, Harry N. Memery, Chairman - 1976, Roland F. Stebbins, James G. Fitzpatrick.

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AMA National Leadership Conference

January 23, 1976

As we open a New Year and our nation's Bicentennial, many Americans, and I'm sure many physicians, wonder whether there is much to celebrate. Confidence and trust in our institutions and in our political leaders is at a low point. The problems of foreign affairs, inflation, racial equality, unemployment, urban and environmental decay seem insurmountable. For physicians and surgeons, the issues of ever more burdensome malpractice expenses, increasing governmental regulation, soaring costs, excess demand on resources and time—all these problems seem insoluble.

If we wonder whether there is much to celebrate on our 200th birthday, let me share with you something I read not long ago:

"The most divisive war in our history still divides Americans. A United States Army force has been defeated by ill-equipped guerillas. The American elective process has been contravened. The most deadly sort of racism is rampant and the law is oppressive. A Presidential administration has been exposed as corrupt. The economy is in a shambles. Crime is rising. Our citizens live in fearfully overcrowded cities and many of their children are denied a basic education.

Is this a time to have a national birthday party?

All of these points were raised when the United States was celebrating its Centennial in 1876. The memory of the Civil War was still vivid, and even as Philadelphia began its Centennial observance, word came that General Custer's command had been slaughtered at the Little Big Horn. Samuel B. Tilden had outpolled Rutherford B. Hayes but Congress handed the Presidency to Hayes. The Ku Klux Klan was riding high and Texas was living under the Lynch Law. The Grant Administration had been virtually dismantled by scandal. The country was still reeling from the 1873 panic and workers found their incomes slashed by as much as 50 per cent. In Philadelphia the murder rate jumped 75 per cent during the Centennial year. In New York more than 250,000 people were found living in a single square mile area. Of 600 school-age children living in the Five Point Section of New York, only nine were attending school.

Why celebrate then? Why celebrate now?"

(New York Times, May 18, 1975)

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The best reason for celebrating an anniversary of our nation is that we should pause to reflect on what we were—and what we are—and what we are to become.

What we are to become is a crucial question for all Americans in 1976. In this bicentennial year, what is the overriding issue facing Americans in general, and professionals in particular? I submit that it is the need to reconcile the rights of individuals with the demands of an increasingly complex and regulated society. Throughout American history there has always existed tension between the needs of individuals and those of society at large. But the creative balance between individual rights and collective needs is threatened today by the unprecedented growth and proliferation of government and bureaucracy.

When government deals with a problem in this vast and varied nation, it necessarily deals with the problem in mass. It attempts to write rules and regulations designed to cover every situation throughout America. In the field of health care, government deals with millions of patients, hundreds of thousands of doctors, thousands of hospitals, and billions of dollars.

The hallmark of professionalism, on the other hand, is an abiding and overriding concern with the rights and needs of individuals. Physicians and attorneys owe duties to society at large, but their paramount obligation is to provide the very best service to individual patients or clients. When a physician cares for a patient, he or she deals with one patient only, one individual, one life. And no two patients, no two lives are alike.

There are those who suggest that the answer is to cut back on government. Much as we might wish that that could be done, I believe big government is here to stay. Even if governmental budgets and payrolls were cut in half, there would still remain a mammoth governmental and bureaucratic establishment in our nation. HEW's regulatory output is now some 5,000 regulations a year. The health industry is now one of the largest in the country, employing 4.5 million people, double the number 25 years ago. Spending for health now is more than $100 billion each year, more than 8% of the gross national product.

A direct and necessary consequence of governmental growth is an ever increasing danger that the rights and needs of individuals will be neglected. Physicians, indeed all professionals, must work to protect these individual rights and serve these individual needs. Given the continuing existence of mass government and bureaucracy, the task for the professions is to respond vigorously and creatively to governmental actions which threaten the values of professionalism and the rights of individual citizens—but the task for the private professions is to act effectively in the public interest.

As a lawyer for twenty-five years in both government and private practice, I have learned certain lessons. In dealing with government, there is a time to fight. On some issues, the only response must be "Never—This far and no farther." On other issues, the more productive response is to persuade and negotiate. Most laws, regulations, and government programs are attempts to solve

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serious social problems. In the long run, the successful strategy is to know when to stand firm and when to compromise. It is not enough simply to oppose ill-conceived laws and regulations; it is also necessary to fashion constructive alternatives. And who knows more about how to improve health care than you, the physicians of America?

Our firm, Sidley & Austin, has served as legal counsel to the American Medical Association in a number of matters the past few years. It has been a special privilege to work with Dr. Sammons and Bernie Hirsh and their colleagues. This evening, I would like to share with you two examples of the way in which your Association has responded and should respond to governmental actions which pose substantial danger to the most deeply held values of professionalism.

Last year the United States Department of Health, Education and Welfare promulgated utilization review regulations requiring that every hospitalization of every Medicare and Medicaid patient be reviewed by a committee within 24 hours after admission. While the American Medical Association supports and has long worked to develop reasonable systems of utilization review, the Association was strongly opposed to the HEW scheme. Indeed, the regulations posed an almost classic example of conflict between governmental objectives of mass regulation and individual needs. The government sought to impose a uniform system of admission without regard to the individual circumstances of particular patients. The Association recognized that requiring 24-hour review by committee for all patients in all circumstances would injure those patients for whom meaningful review could not take place within the impossiby short period of 24 hours.

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Therefore, for the first time in its history, the Association brought suit in federal court against HEW regulations, and, after a strenuous legal battle, obtained a preliminary injunction. The government appealed, but the United States Court of Appeals, sitting in Chicago, affirmed the injunction. These court decisions were important for your profession and for the individual patients whom you are sworn to serve. They constitute *the first* judicial recognition that the principle written into the Medicare Law that the federal government may not interfere with the practice of medicine can stand as a beacon to protect the rights of individuals.

While a significant victory, the injunction was only preliminary—a legal mechanism to preserve the *status quo* pending a full trial on the merits. Moreover, even if the Association were to prevail at the trial on the merits, HEW could make relatively minor changes in the regulations and thus force the Association to start a new lawsuit all over again. The Association decided, therefore, to sit down with HEW and attempt to work out a solution.

The litigation was important because it got HEW to withdraw the challenged regulations and to come to the conference table. The results of the discussions that followed are most promising. Although no new regulations have as yet been issued, HEW appears to have committed itself to a more flexible approach—taking into greater account the circumstances of individual patients and local institutions. And Congress itself has now acted to make clear that it never intended 24-hour review of the admission of every Medicare or Medicaid patient. In sum, the AMA, by combining aggressive and prompt litigation with a reasonable and constructive approach, was able to protect the rights and needs of individual patients and their dedicated physicians in a meaningful way.

A second example of the crisis facing the medical profession has only just begun. As you all know, the Federal Trade Commission, without prior notice, filed a formal complaint last month challenging the AMA's code of ethics concerning solicitation of patients and advertising of medical services.

There is perhaps no better example of the clash between governmental mass "solutions" and individualistic professional values. The Federal Trade Commission seeks to analogize medical services which are tailored to the specific needs and circumstances of an individual patient to mass marketed consumer products such as soap and deodorant. Rather than stressing quality of care and independent professional judgment concerning the needs of a particular patient, the FTC would encourage and permit physicians to promote and sell medical care on a mass basis.

Santayana once said that those who do not study history are condemned to repeat it. In closing its eyes to the considerations of professionalism that led to the ban on solicitation by physicians, the FTC would again expose Americans to the deception of the quack and the seduction of the huckster. As former chairman of the Federal Communications Commission, I am reminded of the fight in the 1920's between the government and Dr. J. R. Brinkley of Millford, Kansas. The FCC fought, successfully, to stop Dr. Brinkley from advertising his medical practice on the radio, in a most unorthodox manner. Here's the way it was:

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Once again, however, it is not enough simply to say, "No." The AMA must take the lead in finding positive and constructive solutions to the problem of providing consumer information. Local medical societies have for years sponsored physician referral services. Now the task is to make a greater effort to alert the average layman of their existence and to devise other solutions to the problem of providing adequate consumer information without solicitation. Only through constructive alternatives will the Association most effectively accomplish its mission to defend professional values and thus to secure individual rights.

The other day, I came across a speech in which Kingman Brewster, President of Yale, thoughtfully analyzed the problems private universities face in preserving academic freedom as they become more dependent on government support. Dr. Brewster said this:

"First, we should exhaust ways of encouraging private decisions in the public interest before resorting to government allocations or regulations. Second, when government must act as investor in defense, health and education, it should use market mechanisms so that who benefits will not depend on the favoritism of bureaucrats and politicians. Third, when government has to exercise its discretion in awarding favors or imposing penalties, we should fine some way of assuring redress against its abuse."

These three points apply equally to the efforts and principles which I believe the American Medical Association, acting on behalf of America's physicians, must stress, over and over again—to preserve professionalism, to preserve individualism and to preserve the integrity of the relationship between an individual patient and his physician.

In closing, I'd like to make a few more personal comments. We live in a time of such rapid development that few of us realize how our most fundamental notions are changing. Take the concept of "risk." Formerly, people believed that they bore the risk of misfortune befalling them through no fault of their own. If something went wrong, they would have to rely on their resources or those of their family. Today, people increasingly believe that someone else should take the consequences of misfortune. They would hold society responsible if things go wrong.

When I was in law school, we were taught to ask, "Who is at fault?." My daughter, in law school today, is taught that the real question is "Who is best able to pay?" Therein lies the root of the malpractice crisis.

You, the physician, cannot take all the risks simply because you have greater resources than other segments of society. But unless physicians want to report in the tricentennial year that there once was a concept called professionalism, it is not enough to long for yesterday. You will have to find new solutions, new approaches, and new ideas. The ideas and debate thus far have, for the most part, amounted to plugging fingers in the breaking dike. Far more fundamental and basic changes are needed, and I know that your general counsel, Bernie Hirsh, has some concepts and approaches which go to the roots of the problem—not merely its symptoms.

Individual physicians are among the most respected members of our society. Almost every layman has personal knowledge of situations in which physicians have taken decisive yet compassionate action to preserve life and health. Yet, physicians collectively are viewed with suspicion and mistrust. Part of this mistrust is a result of a general public cynicism toward any collective political activity, by any group. But I suggest to you that another reason for this public suspicion is that physicians are so enormously busy in their individual professional lives and responsibilities that their collective acts are too frequently confined to resistance and opposition—negative actions which are perceived by the public (rightly or wrongly) as self-interested opposition to change.

As individuals and as members of organized medicine, you must speak out more on all issues confronting medicine and health. I urge you NOT TO confine your activities merely to a narrow range of issues affecting only physicians. Physicians should be speaking out—as you are beginning to do—on the effect of television violence on our youth, on the effect of pollution on our health, on crime and its relationship to our health, on occupational safety, on facilities for the handicapped, and on professional ethics—to name just a few. You are citizens as well as doctors. You represent some of the best minds in the nation. What you think and what you have to say should be heard, not only in defense of the medical profession, but affirmatively for all of us, for your children and for my children, and for the quality of American life.

As we start our nation's third century, I leave with you President Kennedy's favorite story, one I heard him tell not long before he was killed. A French Marshal named Lyautey was walking in his garden one morning with his gardener. The Marshal paused at a certain point, and asked the gardener to plant a tree at that spot the next day. The gardener said, "But the tree will not bloom for 100 years." The Marshal looked at the gardener, and replied, "In that case, you'd better plant it this afternoon."

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HDMS'S WOMAN'S AUXILIARY

The annual meeting and luncheon of the Auxiliary was held May 4 at the Colony Club. The group saw the installation of new officers and heard an informative talk by Mr. Perry Mavrelis, a local decorator.

Our own Mrs. William Cummings, second vice-president of the Massachusetts Auxiliary installed the 1976-77 officers. They are: President, Mrs. William Yorzyk; President-Elect, Mrs. Robert Bye; Recording Secretary, Mrs. Carl Janovsky; Corresponding Secretary, Mrs. Ralph Giantelly; Treasurer, Mrs. Peter Lynch; Scholarship Treasurer, Mrs. Freeman Botnick; Directors, Mrs. Walton Stevens, Mrs. Kulin Shah, Mrs. Harry Baker.

The 76-77 Board looks forward to the continuing support of the membership in what promises to be an exciting and innovative year.

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Many of you do a number of volunteer jobs while happily raising your family. Who can forget the Brownies, Girl Scouts, Den Mother days, rummage sales, bringing art to school, PTA, church bazaars, etc., or any one of many community projects. They served as an outlet for you at the time, but you were gaining valuable experience working with a variety of people under different circumstances, at some later date, valuable to you, should you enter the work field.

Why did you volunteer? No doubt for many reasons. Basically you strongly believed in the cause and, more selfishly, found it stimulating and fun to get out with your own peer group. Some of the nicest people you meet and the close friendships you make in a community are volunteers. They are because they care. They are willing to expend that extra amount of energy it takes to get out and do something totally foreign from housekeeping, etc. There is no satisfaction greater than giving of yourself to someone in need.

And, as you look back in history, our country was built on the volunteer spirit.

Let us hope our children will benefit from our volunteer experiences and, as they grow, learn not to ask but give of themselves too. What a better world it would be.

Have you found a volunteer job that fits you best? If not, call your hospital for placement.

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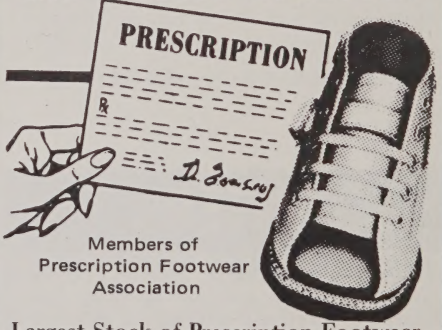

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Minutes of the Executive Committee Meeting

The Executive Committee met at 7:30 p.m. on Tuesday April 20, 1976. Present were Drs. Stoler, Walthal, Moore, Bloom, Lynn, Cox, Kelly, Stoddard, McKenna, and Mrs. Vivian Purdy.

The minutes of the March Meeting were read and accepted.

Correspondence

A member protested the stand taken by Dr. Alfano, President of MMS, on House Bill #3160. It was agreed that Dr. Alfano's stand was not necessarily that of the membership and a letter of protest will be written to Dr. Alfano.

Advertisements regarding treatment of acne by a local aesthetisian was noted in the local newspaper and will be brought to the attention of the Attorney General's office.

Dr. Boss Sr. will be unable to receive his fifty year medicine certificate in person so it will be sent to him.

The objection of the Cancer Cooperative regarding HDMS referral of patients to Oncologists at patients requests or by the Massachusetts Division of the American Cancer Society was noted. It was felt that the present system will not be changed.

Dr. Huston kindly donated framed pictures depicting medicine in the 17th century to the Society.

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Old Business

The issue of specialty listings in the yellow pages of the telephone book is still not solved. It was noted that the telephone company failed to list a local physicians specialty and therefore periodic advertisements will be sponsored by the telephone company for the benefit of the physician.

New Business

The Treasurers report was outlined by Dr. Moore and was discussed prior to its submission to the membership at the annual meeting.

The HDMS expressed the desire to cooperate with local health departments in the proper distribution of swine flue vaccine if and when the vaccine is distributed as determined by the health commissioner.

The difficulty an HDMS member found in entering the Countway Library in Boston was brought to the attention of the Executive Committee and a letter of apology was written from the Countway. It was pointed out that if physicians wish to gain entrance they may ask for ID cards.

It was noted that the National High Blood Pressure month is the month of May and the Public Relations Committee will publicize this fact.

The meeting adjorned at 10:17 p.m.

P. Stoddard, M.D.

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News Release

Springfield Technical Community College has received notification from the United States Department of Health, Education and Welfare that the amount of Basic Educational Opportunity Grant (BEOG) funds being made available to STCC students has been increased to $690,000 for the present academic year, announced Dr. Robert C. Geitz, President of STCC.

The amount authorized is more than twice that of last year, noted Geitz, indicating a large increase in both numbers of eligible students and in size of grants per student. Over 45% of STCC's enrollment is from low income groups.

BEOG is a Federal grant based on family income and other factors such as amount of assets, size of family, number of dependents attending college and medical or other unusual expenses. If eligible, a student can receive up to $900 in Basic Educational Opportunity Grants each school year while attending STCC—for use toward tuition, fees, books and even transportation and basic living expenses while in college.

In addition to the BEOG, students may be eligible for various other scholarships, loans, or employment opportunities, including the Massachusetts State Scholarship, Supplemental Educational Opportunity Grant, National Direct Student Loan and Federal and State Disadvantaged Work/Study Funds as well as various Scholarship Funds such as the Scibelli Fund and the Nelen Fund. "There is nearly always a way to finance college expenses at STCC, even if one's family income resources are modest," says Mr. Wayne Nelson, STCC Financial Aid Officer. For maximum consideration, applicants for financial aid should apply prior to May 15, although late applicants will be considered as well.

For further information prospective students should contact the Financial Aid Office at STCC.

Medicine Thru the Years

by Margaret Stoler

When Springfield began preparing for its 300th Anniversary in 1936, the Springfield Academy of Medicine commissioned Miss Harriet Ellis to paint six oil paintings, each depicting fifty years of development in the medical history of the city from 1636 to 1936.

Miss Ellis, a native of Springfield, was one of the out-standing artists in the city at the time. A charter member of the Artists Guild and the Springfield Art League, as well as a former supervisor of art in the public school system, Miss Ellis enthusiastically accepted the challenge.

The paintings, which hang in the Springfield Academy of Medicine Library, portray six major changes in the history of medicine; from the Clerical-doctor to the Early Twentieth Century physician. With the phenominal advances in medical research over the past forty years, perhaps another painting should be added, dedicated to The Medical Specialist.

1636-1686—Clerical Doctor

Medicine in the early colonial days was far more specialized than you may think. For a fever, the minister would not only pray for you but would also place leaches on your body to suck out the bad blood; for an infected arm or leg, the barber-surgeon would gladly amputate and if it was just a case of "not feeling good," the tavern-keeper would offer you a concoction of fermented grain sure to cure all ills.

In all fairness, the educated minister was the greatest source of medical care in the early days. Frequently he was the only person in the village that could read, could correspond with others for advice. Most ministers possessed a notebook on herbs used for medicine. They also put a great deal of faith in God's help. Epidemics were a sign of God's displeasure. Consequently, fasts were held throughout the village in hopes God would forgive them and end the state of misery.

One of the earliest minister-physicians in New England was Dr. John Fuller who arrived with his wife in the colony in 1623. He traveled through the early settlements caring for the sick. Frequently he served to settle disputes between the early villages, for he was the only physician and no villager wanted to be without his services when needed. Dr. Fuller died in 1633, his wife continued to practice midwifery until her death in 1663.

Reverend John Winthrope Jr. was also well versed in medicine. He frequently received letters from settlers in other colonies asking for advice. In 1652, he received a letter from Sam Stone of Hartford about his son's Jaundice. Winthrope recommended "Barbaric Barke, boiled Beer saffron, twice a day . . . with turmerick three times a day for vomiting."

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In 1667, Parson Samuel Swift published a broadside concerning the means of diagnosing Uroscopy. "If you see your Face in Her Water, if she have not a fever, she is with child . . . if the urine is Bright and Gold the trouble with the patient is Lust or desire to marry."

He also recommended bathing severe burns in the blood of a newly killed cat.

There were, of course, many charlatans at the time. Nicholas Knapp was fined and whipped in 1631 for pretending to cure scurvy with "water no worth no value which he sold at a very deare rate." The Indians had been successfully curing scurvy long before the colonists arrived with a mixture of boiled cranberries.

Not until 1649 where any laws passed regulating medical practices in the colony but they only demanded that no bodily harm be inflicted and that the physician must have the patent's consent.

Though most of medicine in the period was practiced by worried mothers and wives, several known incidents were recorded regarding women in medicine. Anne Hutchingson was known for her healing powers before she was driven out of the colony for her religious beliefs and in 1661, Margaret Jones was "Hung as a witch because her "potions were too good—wonderous cures." They must have been concocked by the devil. In the western part of the colony the records for 1675 show that Mrs. Allyn was paid 20 pounds by the council of Connecticut for her services to the sick.

Much of the medicine practiced in the Connecticut valley was done by leading citizens. Rev. George Moxon was credited with many successful cures, as was William Pynchon, George Filer was the first "chisurgeon" practicing in Northampton in 1665 and Lieut. Thomas Cooper was known for setting broken bones. He was also a carpenter, an attorney, and auditor and a farmer. Such was the versatility of the 17th century physician.

1686-1736

By the late 1600's those practicing medicine were not just ministers, barbers or tavern keepers, Savage's *Geneological Dictionary* claims there were one hundred and thirty four medical practitioners in all the colonies in 1694. Included in the list were 5 school teachers, one poet, 4 weavers and a woman "employed

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by her own sex." By 1721 Dr. Samuel Douglas was the only "graduated" physician in all of Boston.

Most of those practicing medicine served as apprentices under practitioners until they felt capable enough to begin their own practices.

Epidemics continually ravaged the colony. The earliest wave of small pox occurred in 1693. A quarantine hospital was erected on Spectacle Island specifically for infectious diseases. Little was known about the disease which frequently wracked the community. Dr. Thomas Thacher, in 1719, describes it thus:

"a disease of boiling blood that is turning into a new form and state of impurities—it comes out of the veins into the flesh then from flesh to the skin where it makes pox. If you apply heat they will return to the flesh and poison the system. Patient must be kept cool to normal."

Rev. Increase Mather is credited with introducing the first innoculation against small pox in the colony. In 1721 he read of a successful innoculation being used in Turkey. A battle raged between Mather and Dr. Douglas who strongly opposed such means. When Dr. Mather publicly announced that Dr. Zabdiel Boyleston would innoculate his entire family, a grenade was tossed into the Mather house. Fortunately it did not discharge.

Though the illnesses of the times were plentiful and very painful, some of the remedies seem even worse. In the December 18, 1733 edition of the Boston Gazette is an advertisement for a book called *Examples of Great Medicine* with these sub-titles; Medicine out of Soot; Medical Virtues of Humane Urine, Use of Horse Dung (the juices of which were good for stoppage of urine and certain other complaints). Picking the gums with the bill of an osprey was a sure cure for toothaches. There was even a remedy for excessive sorrow, an herbal mixture concocked by Rev. Samuel Willard who recommended it be made available at funerals.

The Hampden County records reveal that the earliest paid practitioner was John Sherman, a school master in Longmeadow, who in 1709 minstered to John Maillifield. Mr. Maillifield was passing through the area on his way to Springfield. Unfortunately, the man died but, fortuantely, he left his entire estate to the Springfield poor. The first trained physician in the area was Dr. John Leonard. Little is known of his education but he was paid for attending the indigent from 1728 to the time of his death in 1744. He is buried in Federal Hill.

1736-1786

Actually medical progress in the Massachusetts colony was considerably

Ernest A. Byron, Jr.

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impeded by the strong influence of the clergy. Up to 1750 only nine Harvard graduates went on to get medical degrees in Europe, and not until 1781 was the Medical Department of Harvard College created. Most of those serving in the Revolutionary War were apprentice trained. Not until 1760 was a law passed forbidding anyone to practice medicine who had not submitted to an examination drawn up by practicing physicians.

In the late 1760 another small pox epidemic hit the colony. In Boston innoculation hospitals were set up on Castle William (Fort Independence) and Shirley Point. Of those innoculated only one in sixty-eight died, of those not innoculated, one in ten died. Unfortunately, Springfield did not yet approve of innoculation and Dr. Charles Pynchon, who had begun innoculating his patients was publicly chastized and ordered at the town meeting to immediately stop the practice.

Unlike today, physicians were very active in politics. Twenty three members of the Massachusetts Provincial Congress were physicians. One of which was Springfield's Dr. Chauncey Brewer, and four physicians signed the Declaration of Independence. Dr. Joseph Pynchon served on the General Court and Chief Justice William Whiting, a physician from Great Barrington, was one of the strongest rebels in Shay's Rebellion.

Little is known of conditions in Springfield, medicalwise, during the Revolution. A hospital apparently was erected for the records show that on January 15, 1778, Dr. Pynchon requested "three saspans, six porrenjars, two coffee pots and 1 close stool pan be delivered to the hospital." In the same year, Dr. Edward Chapin was appointed physician for the families of the thirteen Springfield men indicted into the army.

In 1781 the Massachusetts Medical Society was formed with thirty one Charter members, six from western Massachusetts. It provided greater regulations of excellence in education required for admission. From its inception to the present, it has held regular meetings. In 1790, the first issue of Medical Papers was published, Physicians reported on unusual cases and successful cures. Eventually this publication became the New England Journal of Medicine which is still being published today.

1786-1836

Even with the regulations instituted by the Massachusetts Medical Society, medicine was still quite primitive at the end of the century. In the rural areas, bleeding was still prevalent. One rural physician claimed he could load a boat with the Calomel he had prescribed and float it on the blood he had drawn from his patients.

Progress was made regarding innoculation. Dr. Benjamin Waterhouse of Cambridge introduced Dr. Edward Jenner's vaccination in 1799. The Boston Board of Health set up a clinic on "Noodle Hill" (East Boston) for innoculation; some rather bold experiments were carried on. Nineteen boys were vaccinated; twelve of those were then innoculated with small pox; two fell seriously ill but, fortunately, survived the experiment. By 1810, vaccination was compulsory in the state.

Another major advance was legalization of the study of anatomy which required cadavors. The struggle between physician and clergy over the right to use cadavors began after the Revolutionary War. Fortunately there were those who readily broke the law and supplied bodies from time to time. Dr. W. L. Loring, whose practice in Springfield was not very successful, turned to "body snatching" to supply medical schools. He was arrested and fined $500.00. He left the area shortly after, leaving the grave yards peaceful once again.

In 1827, two Scotsmen in Edinburgh, named Burke and Hare, found an old man lying dead in the street. They took the body to Dr. Robert Knox who paid them handsomely for it. In a very short time they rounded up seventeen drunks, smothered them with pillows and proceeded to sell the bodies to Dr. Knox. The trial served to increase the pressure upon the clergy and in 1831, Massachusetts legalized the use of cadavors in the study of anatomy. The first state to do so.

1836-1886

American medicine was still slow in the mid 1800's. So called medical schools were plentiful but grossly inadequate, lecturing only three months a year with little or no practical experience. Medicine men with their satchels of miracles roamed the byways. One of the favorite cure-alls was Mixture #6 made of cayenne pepper, steam and lobelia, "one dose of which was enough to make a boy willing to go to school for a month." By 1849 there were eighty-six patents made for medicine. Not until the early twentieth century was the Pure Food and Drug Act passed, protecting the public from such quackery. In reference to nineteenth century patent medicines, Arthur Schlesinger Jr. labeled Americans "Homo Americus Robustus" and claimed "a less sturdy nation might have been exterminated" by such medicines.

On May 30, 1840 the Hampden District Medical Society was formed for the purpose of sharing professional knowledge and experience. Regular meetings were held to read essays, discuss pertinent subjects and unusual cases. At the time there were thirty two physicians in Hampden County, by 1850 there were twenty seven physicians in Springfield alone. Today there are seven hundred and thirty one members of Hampden District Medical Society.

One of the most active members was Dr. William Tully who wrote several textbooks on medicine and pharmecology and was the medical consultant for Dr. Noel Webster and Professor Goodrick when they were—creating the Webster Dictionary. Another local physician who wrote extensively of his experiences in the Civil War was Dr. George Otis.

Medicine during the Civil War was quite primitive. Dysentary, typhoid fever and tetanus took more lives than those in combat. In fact, the records show that two thirds of the deaths were caused by sickness and one third by wounds. One of the major misconceptions of the time was that surgical shock was necessary for a successful operation so very little, if any, anesthesia was given during operations. One of the positive aspects was the acceptance of women in the field. Dr. Mary Walker was commissioned by Congress as assistant surgeon in the Union Army.

Following the Civil War, Europe made great strides in medicine but unfortunately, quackery was on the increase in the states. While giants such as Louis Pastuer and Joseph Lister were reducing the mortality rate, American physicians were still consulting the weather to fix the proper day for operations. Not until the late 1880's did we accept and follow Lister's antiseptic principles.

1886-1936

Many advances in medicine were being made in Europe during the latter part of the nineteenth century. The development of the x-ray was a major achievement. Before its full potential could be realized, many charlatans took advantage of the situation. One offered for sale x-ray proof underwear "to prevent exposure of one's private regions." Another major advancement was made by Dr. Gerhard Domagk in Germany who discovered that chemicals could destroy germs; thus the seeds of chemotherapy were sown.

In America, the influx of immigrants created overwhelming problems in the cities. By now the City Sanitary Committees, created in the early part of the nineteenth century, were virtually worthless, merely a rung in the proverbial political ladder. As the mayor of New York claimed during the Cholera epidemic: "I consider the Board more dangerous to the city than the Cholera." So diseases continued to spread, keeping the population under control.

In 1894, a Board of Registration was created in Massachusetts to counteract the increase in quackery. It provided a thorough medical examination for those wishing to practice medicine in the state.

In 1906 the Springfield Academy of Medicine was created with Dr. W. A. Smith serving as its first president. The Academy's major purpose is to offer post graduate courses to local physicians and to further public knowledge of the progress being made in the field of medicine. Out of the Academy has grown the Springfield Academy of Medicine's Library at 1400 State Street. The library serves all local hospitals and physicians, as well as local colleges and secondary schools.

Over the last forty years medical research has continued to grow by leaps and bounds. No longer can one may be sufficiently versed in all aspects of medicine to offer the best medical care available, consequently physicians must specialize. Along with the creations of miracle drugs, problems have arisen, problems such as increased birth rates and decreased death rates; the possibility of long range side-effects such as those effecting the next generation. In the fourth century B.C. Hippocrates stated:

"The physician who strives after wisdom is equal to the God's."

As usual, progress demands a price, solutions create new problems. In a sense, modern medicine can be disasterous unless tempered with wisdom, not only on the part of the physician but on society itself.

Ed's Note: The paintings here in described hang in the rooms of the Springfield Academy of Medicine, 1414 State Street.

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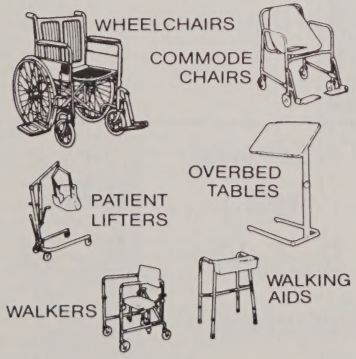

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A Dangerous Drug*

In the past month, six adolescents in the Springfield area have sought medical treatment for the undesirable effects of PCP. The Drug Abuse Foundation of Pioneer Valley, Inc. wishes to alert the medical community to the potentially harmful and lethal drug which has evidently "surfaced" in this region.

PCP is phencyclidine and was introduced in the 1960's to this country from England as Sernyl, a short acting analgesic and anaesthetic for humans and animals.[1] The resultant post-operative effects of hallucination and confusion led to its discontinuance as a drug for humans. It is now marketed in the U.S.A. as Sernylan, a potent immobilizer and anaesthetic for monkeys and other primates. Licit PCP is manufactured only in liquid form.[2] It is officially classified with LSD and Barbiturates as having a depressant effect on the Central Nervous System.

In the 1960's PCP in powder form was smuggled into the San Francisco area from some foreign country. It was immediately accepted by the "Hippies" and other hallucinogenic drug abusers.[3] They called it the Peace Pill, hence the name PCP. Sprinkled on dry parsley leaves or low grade Marihuana, it was called "Angel Dust."[4] It wasn't long before this drug crossed the continent and in New York City it was known as "Hog."[5] There are now many clandestine laboratories that produce an impure form of PCP. Its impurities may be even more toxic than the drug itself leading to hallucinations, coma, and death. From 1970 to 1975 there were 14 deaths in California attributed to PCP. This drug is now a primary constituent of many of the "street" drugs such as LSD, mescaline, psilocybin, THC, cocaine, and amphetamines.[6]

Physicians are warned that the alleged name of the drug causing a crisis should not be trusted. PCP causes greater dissociation than LSD, strong depersonalization, and symptoms of Schizophrenia. The line between "effective" dose and lethal dose is a narrow one. Other symptoms produced by this drug are excessive verbalization, delirium, akinetic mutism, and hallucinogenic actions.[7]

Thus far, no potent antidote has been found for abuse or overdose of PCP. Treatment should consist of keeping the patient in a quiet, dimly lit room, never leaving him alone. Haloperidol (haldol) has been suggested for modification of the effects of PCP. An initial intramuscular dose of 3 to 5 mgms should be given followed by 1.5 to 3 mgm orally three times a day.[8] Recently, diazepam (Valium) has been reported as effective against PCP abuse. An initial intramuscular dose of 10 mgms, followed by 10 mgms orally three times a day have been advised.

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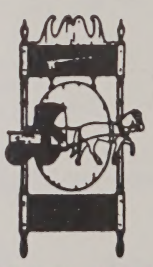

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **WARNING**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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HYDROCHLOROTHIAZIDE TO HELP KEEP BLOOD PRESSURE DOWN AND TRIAMTERENE TO HELP KEEP POTASSIUM LEVELS UP

Dancing—A Hobby for All Seasons

There is no doubt that dancing is the most popular participant or spectator sport and form of recreation the world has ever known. Only eating, drinking and making love are more ancient in origin. The desire to dance is one of the primitive instincts of mankind.

As a hobby dancing offers to the enthusiast a mental and physical recreation which can scarcely be equalled. Taken seriously it offers as much physical exercise of the desirable aerobic type as anyone could wish without the boredom or weather restrictions of jogging or cycling. Mentally it offers a needed change of pace and suspension of harrassing day-to-day problems necessary for all of us. Far superior to tranquilizers or alcohol, it is a great unwinder.

The social aspects of dancing are well known and need no further comment, but we wonder how many appreciate how a hobby shared by husband and wife can bind a marriage and strengthen family ties.

There is a type and level of dancing for all people, large, small, young, old, coordinated or not, athletic or sedentary. It requires only a source of music, a little floor space and a modicum of desire.

Kae and I have danced together for over ten years, starting with square dancing then to round dancing and currently are deeply involved in the international type of ballroom dancing. Along the way one or both of us have dabbled in ballet and modern jazz. Our type of ballroom dancing has been a world-wide competitive event for many years at both amateur and professional levels. In contrast to the social type of ballroom dancing seen mostly in this country, these events demonstrate beauty of movement, perfection of lines, a flowing style and extreme competitiveness, very much like the ice dancing event recently seen in the Winter Olympics at Innsbruck.

Spectator interest is quite high throughout Europe, Australia, Japan and South Africa with many top competitions, including the World Championship to be held this year in Germany, being carried by the British Broadcasting Company. Contested events include in the so-called Modern category: Waltz, Foxtrot, Quickstep and Tango; and, the Latin group: Samba, Rhumba, Cha-Cha and Paso-Doble. American Swing or Jive and the Viennese Waltz are included in world competitions.

While Kae and I practice daily for approximately one hour and receive at least six hours a month coaching from top professionals, this is not necessary for dancing to be truly a relaxing and enjoyable experience. To reach a reasonable standard of dancing efficiency is neither laborious nor difficult and need not be expensive. A few lessons from a good teacher (don't sign contracts) will allow any beginning dancer to move comfortably, easily and rhythmically on the dance floor.

As we observed at the latest White Cap Ball, many local physicians and their partners have already discovered the benefits of this activity and are quite competent terpsichoreans. However, with this article we are trying to reach those less fortunate persons who may be suffering from an ailment common to many physicians.

1. Are you emotionally drained by patient responsibilities at the end of each day?

2. Do you neglect to get the amount of physical exercise you know you need? Is it limited to trumping partner's ace or lifting a glass?

3. Does your wife complain that you don't love her anymore? Do you?

4. Does your weekly escape to the golf course leave you feeling guilty? Does it cost an arm and a leg?

5. Does your foot tend to tap spasmodically when you hear the sounds of Goodman, Dorsey, Miller, et al?

6. Does the smell of gardenias conjure in your mind a senior prom of years ago?

7. Do you know that the word "hustle" means more than a pool shark or a lady of easy virtue?

If the answer to any of the above questions is "yes," you may have an occult form of danceaphilia which, if untreated, can have serious long-term consequences.

Fortunately, the treatment of this condition is relatively painless, easy, and usually quite successful, consisting of a prescription for dancing in any form and it may be refilled p.r.n.

We are strictly amateurs, but quite willing to offer our advice or answer any questions this article may stimulate to anyone wanting to get started or want more challenge in dancing.

As with any hobbyists, part of the fun is talking about it.

Dr. Paul and Kae Nay

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of others
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—Edwin Markham

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